REFERRAL FORM SMILE WellDENTAL

Section for Staff

- **Referring Doctor** _____
- **Referring Office's Name** _____
- **Referring Office Phone number** _____
- **Date** DD / MM / YYYY _____

Our Branches

☐ **SURREY**
(778) 877-3493
info@smilewelldentalsurrey.com
15243 91 Ave #2 , Surrey, BC

☐ **LANGLEY**
(778) 340-2897
info@smilewelldentallangley.com
A125 & A130 20487 65 Ave, Langley, BC

Patient Infomation

Patient Name Last _____ First _____ **Date of Birth** DD / MM / YYYY _____

Address _____ **Postal Code** _____

Contact Cell _____ Home _____

Dental Insurrance
☐ Group Insurrance (1st) ☐ CDCP (no. _____)
☐ Group Insurrance (2nd) ☐ No

Section for Dentist

Medical Information
☐ Mental/ Physical issue ☐ Patient is on wheelchair ☐ Dental Anxiety
☐ Hard to anesthesize ☐ Gagging issue

X-ray Enclosed
☐ Emailed ☐ Patient will bring the X-ray(s) ☐ No

Type of X-ray
☐ Panorama ☐ CT ☐ PA ☐ BW *X-ray(s) was taken on D____M____Y_____

TREATMENT NEEDED
☐ I.V. Sedation ☐ N20 Sedation ☐ Surgical Extraction
☐ Implant ☐ Filling ☐ Others: Specify _____

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
			55	54	53	52	51	61	62	63	64	65			
			85	84	83	82	81	71	72	73	74	75			
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Comments _____

_____

Signature of Referring Dentist _____